

Help Me Decidex

Help for your healthcare options

●Close

Help Me Decidex

Help You might be eligible for the following benefits

●Close

Help Me Decidex

Help could not determine if you were eligible for the following benefits

●Close

Electronic Application Rights & Responsibilities

Top of Form

	CitizenWorkspac	115	92aa08dc5025e9	-5878270637067	FindAssistanceV	-5878270637067
<?xml version="1						

Please read the following rights and responsibilities. If you disagree with a statement additional questions may appear or your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.

I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, SCDHHS and/or the Marketplace will use income data including information from tax returns of household members. This will determine yearly eligibility for help paying for health insurance for up to the next 5 years. SCDHHS and/or the Marketplace will send me a notice and let me make changes. If I don't, my eligibility will continue

at the level indicated by the data. I understand this renewal process will occur each year for the next 5 years unless I tell SCDHHS and/or the Marketplace that I don't want to renew, or if I leave the Marketplace. I also understand that I can change my answer later. **If I don't check the box, I can select less than 5 years.**

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.

I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.

As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

- A person of any age who was a patient in a nursing facility, intermediate care facility for individuals with intellectual disabilities, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
- A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that if I receive services as part of either of those two groups, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

I know that I must tell SCDHHS if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.

The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match our electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure

that services provided to my family and me are sufficient and necessary.

If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid and CHIP programs, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair review of the action. I must submit a written request for such a hearing to SCDHHS. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

By selecting the box I state that I have read and agree to the rights and responsibilities stated on this page.

Sign this application. The primary applicant should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in the application.

I am signing this application under penalty of perjury. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I'm not truthful, there may be a penalty under federal law.

Bottom of Form